Department of Health

Three Capitol Hill
Providence, RI 02908-5097

TTY: 711
www.health.ri.gov

Health Information Exchange (HIE) Advisory Commission
May 28, 2015
Meeting Minutes

Attendance:
Commission Members: David Gorelick,MD (Chair), Paula Hemond, Nicole Lagace, Lisa Shea, MD, Ted Almon
State Staff: Melissa Lauer, Nicole Alexander-Scott, MD, MPH (Director of Health)
Guests: Laura Adams (Rhode Island Quality Institute), Elaine Fontaine (Rhode Island Quality Institute), Mike Dwyer (Rhode Island Quality Institute), Alok Gupta (Rhode Island Quality Institute), Darlene Morris (Rhode Island Quality Institute), Amy Nunn, ScD (Rhode Island Public Health Institute)

1. **Meeting Called to Order:** at 3:30PM by Chair, Dr. David Gorelick.
   a) Introductions
      a. Dr. Nicole Alexander-Scott introduced herself to the Commission.
   b) A motion was made by Mr. Almon to approve the minutes and seconded by Dr. Shea. The minutes (December 4, 2014) were approved unanimously.

2. **Public Comment:**
   - Ms. Adams commented on the legislation pending, which would require that the HIE Advisory Commission draft a state interoperability roadmap. Ms. Adams spoke at the hearing for the bill about how RIQI is already drafting an interoperability roadmap under the Regional Health Information Organization (RHIO) contract which RIQI has with HEALTH.
   - Mr. Almon asked Ms. Adams about how standards are helping interoperability in the state and country as a whole, and whether standards would be integrated into the Interoperability Roadmap. Ms. Adams responded that she did not think it wise for Rhode Island to have required state standards because national level vendors are not always able to adapt to requirements set state by state, and because standards are constantly evolving. She added that standards have helped considerably in easing the transmission of health data and are continually being developed by stakeholders nationally.
   - Mr. Almon also mentioned that he, while enrolled in CurrentCare, is still unsure of the value and whether it is being used. He mentioned that he was unaware that he enrolled in CurrentCare until he became a Commission member. He asked if there were any plans to help increase knowledge about CurrentCare to the public. Ms. Adams responded that even options such as sending a mailing to everyone who has enrolled are very costly, simply because of the number of people who would need to be reached.

3. Update on HIE Advisory Commission Recommendations

- Access to CurrentCare by other healthcare service providers:
    - Access cannot be provided to payers or staff of payers, such as case managers. Mr. Almon suggested that plans may consider alternate case management schemes, such as placing the case managers at the plans into the practices so they become HIPAA covered.
    - It was questioned whether the Commission should recommend a change to the legislation, but not recommendation was made at this time.
- Providing protection to sensitive behavioral health data (42CFR)
    - Add a watermark: There is currently a bar across the screen which indicates the user is in Part 2 Data.
    - Screen time-out: A screen time-out presents a technical challenge which is doable, but not a project on RIQI's plan this year. It would require funding and could be complicated. Dr. Shea mentions that if practice staff are following good privacy practices it should not be needed because people would never leave their screen unattended. Ms. Morris asks the commission if they believe this should be further pursued. Dr. Shea is concerned that if it becomes a barrier to use, the timeout could be a problem. Mr. Almon agrees with Dr. Shea, and states that he believes it would be a big unnecessary cost to be able to do it. Dr. Gorelick summarizes the commission's feedback that RIQI should not stress the system to meet this recommendation.
- Expanding alerts from simple transactions to an intelligent system:
    - RIQI is working with the vendor InterSystems to implement "Advanced Clinical Notifications" which will come with an upgrade which will occur at the end of this year. This component will provide the ability to add additional triggers to send alerts. Alerts are delivered via a secure Direct e-mail. The current system is simple and triggered only by an ADT message. The expanded functionality is expected to be available to subscribed providers in 2016.
- Develop dashboards for providers/practices to track key clinical parameters:
    - RIQI has prototyped a dashboard which will allow providers to see the patients in their panel who are in a bed at a hospital and/or those who have been admitted, discharged, are in the ER, etc, as well as a trend of patients over the last 6 months. The user will be able to drill down into bar charts and get a listing of which specific patients make up the data point on the chart, as well as see details on an individual patient's status such as why he or she was admitted, when, and current status. This system is also looking at a way to identify that a patient is high risk with more recent data than claims data. Thundermist was very excited by this pilot and felt like they were able to see more detailed information about their patients. RIQI submitted a letter of intent to submit a grant to RI Foundation for additional funding to support the development of this product.
        - Mr. Almon asks if this is a commercially available product which was purchased. Ms. Fontaine answered that yes this is a commercial product offered by their vendor and is intended to be paired with the HIE product. The advantage is that there is a central repository of HIE data and this system is connected to the live database, unlike a lot of business intelligence products.
- Develop alerts for preventive care, cancer screenings, etc.:

- RIQI envisions this will be the next dashboard they will work on and it will be available in 2016.

- Work with providers to track utilization:
  - RIQI will work with the Physician Advisory Committee to prioritize the best measures to include in provider reporting.
    - Dr. Gorelick asks if the physician advisory committee has been reconvened. He details that it was disbanded because the attendance was not great. Ms. Morris states that they decided to break it out into two new committees – the first of which will be the Care Team Advisory Group including physicians and other care team staff. RIQI has identified a list of names including some existing members. These new groups have not started meeting yet.
- Mr. Almon asked as well about the patient portal, even though this was not an official recommendation. Ms. Adams responds that RIQI will receive money in the SIM grant to add to patient engagement. Some features will include uploading documents and patients receiving alerts on themselves and their family. It is unlikely that it will be fully funded by SIM when the use of funds is completed.

4. 2014 Annual Report

- The annual report for 2014 was sent out previously. There need to be corrections to credentials and Nicole Lagace's name is misspelled a couple of times.
- A motion to approve the report with proposed revisions was made by Dr. Shea, and seconded by Ms. Hemond. The 2014 HIE Advisory Commission Annual Report was unanimously approved.

5. Enrollment Update

- Ms. Morris passed out a presentation (attached) regarding enrollment.
- Enrollment status and campaigns
  - There are currently 456,007 Rhode Islanders enrolled. RIQI is aiming to meet the half million mark by the end of 2015.
  - Online enrollments have been slow so far this year, but is best encouraged by e-mails from providers. Coastal Medical sent out an e-mail to their patients and RIQI received 2000 online enrollments.
- Duplicate enrollments
  - There are many duplicates each month and many which also have to be returned because some information is missing. The downside to this is that they still have to be processed, which has a cost. Most of the duplicates come from the hospitals.
  - RIQI has campaigns to reduce duplicate enrollment. Ms. Lagace mentions that this connects to Mr. Almon's previous comment that he never received patient-directed communication about CurrentCare. She too was unsure whether or not she was enrolled even though she had filled out the form.
  - RIQI has calculated what it would cost to send a mailing to patients and found it too large. Unfortunately there is not a requirement that patients include an e-mail address either.
  - Dr. Gorelick adds that physicians might struggle to figure out how to send notifications only to those who have not enrolled, depending upon how a practice records that a patient enrolled

- Enrollment graph by county % of population enrolled
    - Dr. Gorelick asks if RIQI is going to reach out to these other low-enrollment areas.
    - RIQI is attempting to re-engage providers at these practices to push enrollment.
- Enrollment by City and Town % of population enrolled
    - RIQI can identify locations to focus outreach based upon this analysis.
- Enrollment by Age and Gender
    - Younger individuals are not enrolled. The low enrollment in these ages, especially 15 to 19, may be because of adolescent privacy concerns.
    - Mr. Almon asks if babies are being enrolled. Ms. Morris responds that they do get enrolled.
    - When an individual turns 18 they must submit a new enrollment application for themselves.
    - Ms. Adams comments that she will be doing a Grand Rounds at W&I regarding enrollment.
    - Mr. Almon mentions that he is on the board at South County Hospital and they had over 800 births last year. Logic states that if you enroll all babies, far down the line everyone will be enrolled.
- Major Challenges to Enrollment
    - Enrollment acquisition has been transitioned in-house
    - Enrollment processing was sent out of house to Konica/Minolta
    - The subsidy to pay 2-5 dollars to a practice per form no longer exists for providers
    - Child/adolescent privacy concerns
    - Duplicate enrollment rate
    - Inability to grant CurrentCare Viewer access to some groups who could help with enrollment
- Enrollment strategies
    - Patient panel analysis – provider can submit patient panel and receive a report on who is enrolled
    - Online enrollment e-mail or paper letter campaigns
    - Reactivating enrollment partners
    - Community health teams enrolling (NHPRI "Health@Home")
    - Translation of forms in Portuguese and Spanish
    - Product Improvements (e.g. mobile friendly site, already enrolled pop-up)
    - CVS MinuteClinics enrolling per state conditions o do business
    - Community presence (wellness fairs and other events)
    - Communication efforts (newsletters, contests, etc.
    - "How to Enroll" worksheet
    - RI Primary Care Physicians Corporation (RIPCPC) tablet campaign (tablets in waiting rooms with the sole purpose of online CurrentCare enrollment will be deployed soon)
    - Medicaid enrollment workgroup (bi-monthly) led by State HIT Coordinator Amy Zimmerman. Medicaid enrollment is about 35%.
    - Attention to child/adolescent privacy concerns
- Adoption and Use
    - User cite the difficulty of having to leave EHR to go to a different system

- RIQI has been working in this area and numbers are starting to go up. They will continue to work on utilization.
- Cross document exchange is a new project getting off the ground this year, so that physicians will not have to leave their EHR system to review data from CurrentCare
- RIQI presented a use case at WellOne – Patty Kelly-Flis uses CurrentCare to check on missing labs for chronic care patients.

- Questions:
  - Dr. Gorelick asks if there is some way where CurrentCare enrollment could occur at Medicaid enrollment. Ms. Morris mentions that it would be helpful for the state to implement those changes. Mr. Almon adds that this would be a good element to add to the Reinventing Medicaid Commission, but he did not see any mention of CurrentCare in the report.
  - Dr. Gorelick adds that tablets in the office seems like a great idea, and is wondering if there could be some advantage to RIQI giving tablets to practices for enrollment.
    - Ms. Adams adds that while this might have an up-front expense, online enrollment keeps duplicate enrollments and the cost of each enrollment down. There may be some cost savings in providing tablets to practices.
    - Dr. Gorelick suggest that RIQI at least provide support for how to have a CurrentCare enrollment tablet, once RIPCC has tried the tablet and RIQI can see if it works. A practice may be happy to purchase the table if they have help to set it up and configure it.
- Recommendations?
  - Mr. Almon wonders if there is a recommendation around Medicaid enrollment rates in CurrentCare. The HIE Advisory Commission could provide comments to the Reinventing Medicaid Commission. Enrollment is voluntary in CurrentCare, so Dr. Goerlick does not think it should be mandatory for Medicaid patients; however, it could be required that CurrentCare enrollment is offered during a Medicaid enrollment and the enrollee must either say, "Yes, I will enroll," or "No, I will not enroll." Dr. Shea also asks if the CEDARR centers are helping with that because they see Medicaid.
    - Dr. Gorelick is not surprised that younger folks are not enrolled because they do not go to the doctor as often, but high utilizers should enroll. Could it be mandated that before an individual leaves an ER as part of discharge they could be offered to enroll? There are good numbers from some ERs, especially South County. Ms. Hemond believes enrollment occurs at admission to the ER, not at discharge, when it is possible. Bill Sabine who runs the ER at South County would be a good member for the enrollment group.
  - Ms Adams suggests that Medicaid should contact the ERs to encourage enrollment attempts as a Medicaid strategy. It is more powerful as an idea and recommendation from the Director of Health and/or the Director of Medicaid.
  - Mr. Almon adds that if CurrentCare can accomplish the goal of reducing costs and increasing quality, then it makes sense to enroll more people. He mentions the potential benefit of maybe making CurrentCare an opt-out arrangement for Medicaid patients.

        - Dr. Shea does not think that changing the opt-in just for a specific population is fair, since it would be treating one population differently than another.
        - Dr. Shea also thinks it might be better to go through direct consumer outreach to places people gather and convince them to register. Ms. Lagace agrees that community outreach is a great idea, but it may increase duplicate enrollments. She thinks it would be helpful if patients heard about their enrollment to increase their awareness.
    - No official recommendations were decided upon.

5. Schedule and Topics for Future Meetings

- The previously schedule June 4th meeting has been cancelled.
- The August 6th date still works for everyone.
- RIQI Board meetings – Mr. Almon mentioned that he enjoyed attending the board meetings.
- Potential topics:
    - MOLST was a suggested topic previously which was delayed.
    - KIDSNET relation to CurrentCare – Ms. Morris mentions that RIQI is looking at Meaningful Use Stage 3 and how to use the HIE to help providers meet Stage 3. There are 8 objectives in MU Stage 3, and one objective is about registries. There are 6 objectives and providers have to select multiple registries. There is not a clear connection right now. Ms. Adams adds that KIDSNET was the initial HIE in the state. Mr. Gupta mentioned that they could split up consented vs. patient provided data in a compartmentalized HIE where things are not as comingled.
- Prescription Monitoring Program which is housed in the Department of Health
    - Refresher on PMP, regulations, how it is meant to be utilized, how it interfaces with HIE. Dr. Gorelick suggests 10 minutes.
- Ms. Lauer asked at the request of the Director about the Commission member's perceived purpose of the Commission –
    - Dr. Gorelick thinks the meetings are going well and would like more members to increase the quorum
    - Dr. Gorelick also says so far it has worked well to have different topics described by the RIQI, and then the Commission can look at privacy concerns and functionality issues.
    - Mr. Almon adds that it would be welcome for the Director to inform the Commission what she wants advice on.
    - Mr. Almon appreciated the direction given by Dr. Fine, and would find it useful for the new Director, Dr. Alexander-Scott, to articulate her vision of the HIE Advisory Commission.

6. Meeting Adjourned at 4:53 PM